

Release to Return to Work Status

Return form to: Administrative Services Human Resources, PO Box 94905 Lincoln NE 68509 or fax to 402-742-8361 Name of employee Medical Diagnosis																	
Medical Provider: Please complete the following information.																	
Medical Provider: Please c	omplete th	e fol	lowin	ng inf	orma	atior	٦.										
1. Has our employee reached																	
	If NO,	nexts	scneau	nea ap	point	men	t date	e tor (evaiua	ition _							
2. Employee is released to: ☐ full duty without limitations	Date								(o not c	omnlete	augeti	one 3 th	rough 1	11 Sign i	helow)	
modified duty	from				(Do not complete question to (sp								pecify limitations below.)				
		_ `	(sp date							, minicati	OHS DON	J.V.,					
modified hours (specify here)						to _											
		date										date					
							No limit 1 2					Number of Hours 3 4 5 6 7 8					
3. In an eight-hour workday, employee can stand/walk a total					ļ							7	,	Ö	† ′		
4. At one time, employee can stand/walk					<u>'</u>			$\overline{\Box}$				7	$\overline{\sqcap}$	ī			
5. In an eight-hour workday, employee can sit a total of																	
6. At one time, employee can				-													
7. The employee is able to wo	rk in the felle	wina	rango	for lift	ina c	orrvi	na n	uchir	a/nul	lina:	0000	ciona		220/ 0	f tha		
workday or frequently 34-66	% of the wor	willig kdav.	range	101 1111	ilig, c	ai i yi	ng, p	uSiiii	ig/pui	mig.	Occa	SiUlla	ily 0-c)3 / ₀ U	ııııe		
	20 25 30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100	
Occasionall				.					-								
у							Ш							Ш			
8. Employee can use hands for repetitive																	
a Fine manipulation		\Box	Right Yes [: □ No			г	_	Left	l NIG							
a. Fine manipulation b. Pushing and pulling		==	res (Yes	No				_ Ye: _ Ye:		No No		-	Do	minar	nt hand	d	
c. Simple grasping			res [No			<u>-</u>	Ye		l No			□R	Right		eft	
d. Keyboarding		==	res [□ No			-	Ye		No							
9. Employee can use feet for r	epetitive rais				as in o	opera	ating	foot	contro	ols)	П	es [□No				
10. Employee is able to														***************************************	***************************************		
-	Continuously 67-100% of the			Frequen 66% of th				casion			Intern	nittentl			Not at	all	
a. Stoop/bend		uay			ic uay		0-33 /		e uay		1-5 /6 C		ау			ali	
b. Crouch																	
c. Crawl																	
d. Kneel				<u> </u>				<u> </u>				<u> </u>			<u> </u>		
e. Twist	<u>L</u>			<u> </u>								<u> </u>			_뷰		
f. Climb g. Balance				+								<u></u>			ᅮ		
h. Reach				ᆸ				- H -				Ħ			ᅟᅟᅥ		
i. Push/pull												<u> </u>		1	一百		
11. Other functional limitations	or modificati	ons n	iecess	ary in	our e	mplo	yee's	emp	loyme	ent:							
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			IZATIO							1111.							
I hereby authorize my attending Pl										there	of aca	uired	in the	cours	e of m	V	
examination or treatment to my en									•						,		
Employee signature			Em	ployee	print	ed n	ame						Date				
DI																	
Physician Clinic (Address & Pho	1e):																
Physician signature			Phys	ician _l	orinte	d naı	Physician signature Physician printed name										